

## Correspondence

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Editor: Greg Wilkinson

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### Supportive Psychotherapy: A Contradiction in Terms?

SIR: Sidney Crown (*Journal*, February 1988, 152, 266–269) invites readers to comment on the conclusion to his paper on supportive psychotherapy that: "... if it is supportive, it cannot be psychotherapy; if it is psychotherapy, it cannot be supportive".

Dr Crown's subtitle – "a contradiction in terms" – is not the case if we move away from the relatively narrow definition of psychotherapy that has caused so much confusion and difficulty over the years. I have suggested a way out of the conceptual muddle by invoking the idea of the *psychotherapies* (Bloch, 1986). This permits us to conceive of a range of psychological treatments, each distinguishable from the others according to goals, techniques, and target of intervention. We can therefore differentiate between long-term insight-orientated individual therapy, family therapy, marital therapy, sex therapy, brief dynamic individual therapy, crisis intervention, and so forth.

Using this approach, supportive psychotherapy becomes identifiable as a separate entity with its own explicit goals, indications, and definable technical interventions. To be more specific (see Chapter 11 in Bloch (1986) for a full account of these points), supportive therapy is applied in the case of patients who are severely handicapped emotionally and interpersonally and in whom the prospect of basic change is minimal (e.g. chronic schizophrenia, chronic affective disorder, chronic neurosis, and for severe personality disorders). The chief objective of the

treatment is to promote the patient's best possible psychological and social functioning by restoring and reinforcing his abilities to manage his life. Subsidiary goals include: bolstering of self-esteem; reality testing, of the patient's inherent limitations and those of treatment; forestalling relapse and deterioration; and enabling the patient to require only that degree of professional support which will result in his best possible adjustment, and so preventing undue dependency.

The components of therapy are readily definable and available for specific deployment by the therapist: reassurance, explanation, guidance, suggestion, encouragement, permission for catharsis, and affecting changes in the patient's environment. These components are brought into play within the context of a specific form of the therapist-patient relationship, typified by the therapist assuming an explicit helping role, attending to the patient's particular needs, and maintaining only a modest level of closeness.

Dr Crown refers to the alleged contradiction in terms as a paradox. In my view, the paradox revolves around the relative conceptual neglect of supportive therapy on the one hand and its implicit, widespread application in psychiatry on the other hand. Given the chronicity of a sizeable proportion of the conditions psychiatrists deal with, that level of application is much needed. Also much needed, however, is the further elaboration and refinement of the conceptual foundation upon which supportive therapy is practised.

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SIR: The limitations of space prohibiting a point by point discussion of Dr Crown's paper, I shall touch on only three issues which I consider of importance. (I have dealt more fully with supportive psychotherapy elsewhere (Werman, 1984)).

In effect, Dr Crown defines psychotherapy by criteria which limit it to what he calls 'dynamic psychotherapy', or 'insight-oriented psychotherapy' in the terminology I use. Surely, all modes of the "treatment of disease by 'psychic' methods" (the OED definition) must be characterised as psychotherapy, including such disparate treatments as hypnosis, cognitive therapy, behavioural modification, and psychoanalysis. What distinguishes different forms of treatment are their theoretical bases, their goals, and the technical interventions they utilise. Accordingly, I believe that supportive psychotherapy (SP) and dynamic psychotherapy (DP) both rest on an 'overall unifying theory' but differ principally in their goals and techniques. Both therapies are based on psychoanalytical concepts; the goal of DP is the diminution of neurotic conflict and maladaptive character traits through the development, in the patient, of an understanding into the ways in which his or her mind works. In contrast, the goal of supportive psychotherapy is to enhance more or less deficient ego functions. SP tends to deal with the derivatives of disturbances that occurred in the early, pre-oedipal phases of development, such as have been described by A. Freud and Mahler; it thus can be regarded as a treatment of substitution, enhancement, and maintenance.

However, Dr Crown's dichotomisation of SP and DP does not accord well with clinical practice; although both modalities exist in 'pure culture', admixtures are more common, and, in any treatment process, the emphasis from one to the other may shift at any time. Supportive interventions may be indicated, at times, in psychoanalysis when the analysand's ego functioning is momentarily overwhelmed by a traumatic experience. At the other end of the spectrum, patients in SP are not invariably unable to achieve some insight into themselves.

Dr Crown argues that because the transference (the "therapist-patient relationship") in DP may be intense, the therapist should have personal therapy, a need that "does not arise with SP" since the relationship with the patient is "far less emotionally demanding". In contrast, I believe that SP often places a considerable emotional strain on the therapist because these patients tend to use more primitive defences (projecton, denial and splitting), tolerate frustration poorly, and are more given to destructive behaviour. The resultant intense countertransferences are only too well-known. Successful SP, no less than DP, requires a strong relationship with the patient even though the nature of that relationship is quite different from that which is beneficial in DP.

Despite my disagreements with Dr Crown, I am pleased that he has added his voice to those of us who

have been drawing attention to supportive psychotherapy, a form of treatment which I believe is indicated for most psychiatric patients.

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#### Naloxone in Heroin Withdrawal

SIR: I was interested to read the paper by Vlissides *et al* (*Journal*, April 1988, 152, 565-567) on the effects of naloxone during heroin withdrawal, but not surprised by their results. During the past 6 months I have, following an initial naloxone challenge, withdrawn over 50 opiate addicts, mainly from heroin but about a quarter from methadone, and established them on a full dose of naltrexone. This is a modification of the technique described by Kleber *et al* (1987), and it has enabled us to withdraw heroin addicts in an average of less than 24 hours.

In nearly all cases, an intramuscular injection of naloxone (0.8 mg) does indeed precipitate withdrawal symptoms or aggravates established withdrawal, even when patients are premedicated with clonidine (0.3-0.4 mg). However, when about 45 minutes later we give a relatively large dose of oral naltrexone, the subsequent withdrawal symptoms appear to be considerably less than has been our experience with rapid detoxification and naltrexone induction by gradually increasing the dose of naltrexone over a period of two or three days from an initial level of 1 mg (Brewer *et al*, 1988).

Furthermore, despite the increased speed of this withdrawal technique, the total amounts of clonidine and, where necessary, lorazepam needed to control withdrawal symptoms are actually less than with the slower methods. A paper describing this technique has been submitted for publication.

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